Introductory Training for First Steps Providers

Basic Overview of First Steps
Track III

Form 5: Provider Agreement

In both Track I and II we have referred to the Provider Agreement. Having an approved Provider Agreement is essential. If you, as an independent provider, or your agency do not receive an approved provider agreement, signed by the CCSHCN's Executive Director, any services you provide will not be reimbursed.

This Track is intended to help you accurately complete each form. Submitting incomplete forms will delay processing and prevent you from initiating services.

Form 5: Provider Agreement, pg. 1

Rev. 4/10/02.

Leave blank

Provider Number: FS-_____

COMMONWEATH OF KENTUCKY
CABINET FOR HEALTH SERVICES
COMMISSION FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS
FIRST STEPS

Leave blank

PROVIDER AGREEMENT

THIS PROVIDER AGREEMENT, made and entered into as of the _____**day** of _____ **200** ____by and between the Commonwealth of Kentucky, Commission for Children with Special Health Care Needs, Kentucky Early Intervention, 982 Eastern Parkway, Louisville, Kentucky 40217, hereinafter referred to as the Commission and

_____

(Name of Provider)

_____

(Address, City, State, Zip of Provider)

hereinafter referred to as the Provider.

Fill in your Name or the Name of your Business & Address

Form 5: Provider Agreement, pg. 2

Read the full text of the Provider Agreement pages 1 and 2 sign page 2 as shown below:

PROVIDER

Sign Here

BY:_____
Authorized Official
NAME:_____
TITLE:_____
DATE:_____

COMMISSION FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS
BY:_____
Authorized Official
NAME: Eric Friedlander
TITLE: Executive Director
DATE:_____

PRINT Name, Title & the Date

If contract is with an agency, this should be signed by the individual with the authority to sign a legal document

Leave blank

Form 5: Provider Agreement, pg. 3

Read carefully the full text of the Provider Agreement page 3 regarding Violation of Tax & Employment Laws.

_____ The contractor **has** violated the provisions of c
five (5) year period and has revealed such final deter
determination(s) is attached.
_____ The contractor **has not** violated any of the pro
year period.

Check the appropriate statement. If the first statement is checked, attach the statement of findings to the agreement.

APPROVED:

_____
Secretary, Finance and Administration

BY:_____
Cabinet Secretary's Signature

Leave blank

FIRST PARTY:
COMMISSION FOR CHILDREN WITH
SPECIAL HEALTH CARE NEEDS
Name of Agency

Print Here

SECOND PARTY:

Sign Here

_____
Name
BY: _____
Signature Date

Form 5: Provider Agreement, pg. 3

The contact person you designate will be responsible for maintaining communication with the First Steps staff.

Print Information Here

Contact Person responsible for disseminating all information from communication packet to all involved in Early Intervention Services.

NAME: _____

TITLE: _____

ADDRESS: _____

PHONE #: _____

E:MAIL ADDRESS: _____

All service providers required to have a state license must provide the Commission with a current copy.

Submit copy(s) of license(s) with this agreement

Form 6: CBIS Provider Enrollment

The Provider Enrollment form provides for a standardized method to:

- Collect demographic information about your business entity
- Identify employees who will provide services to KEIS recipients
- Report changes to any demographic information

Before completing this form, give careful consideration to your business structure.

- What will you name your business?
- Will you operate using your SS#?
- Where is your business located?

Form 6: CBIS Provider Enrollment

As a new provider, mark this box

12 service providers can be listed on this page. If more than 12, fill in appropriate number of pages

Leave blank

Page 1 of ___

FIRST STEPS CBIS PROVIDER ENROLLMENT FORM **FORM 6 REV. 3/11/2002**

☐ N e w	☐ Annual Renewal	**Provider #**	Date: _____
☐ Addendum *Indicate (A) Add or (D) Delete			District # _____

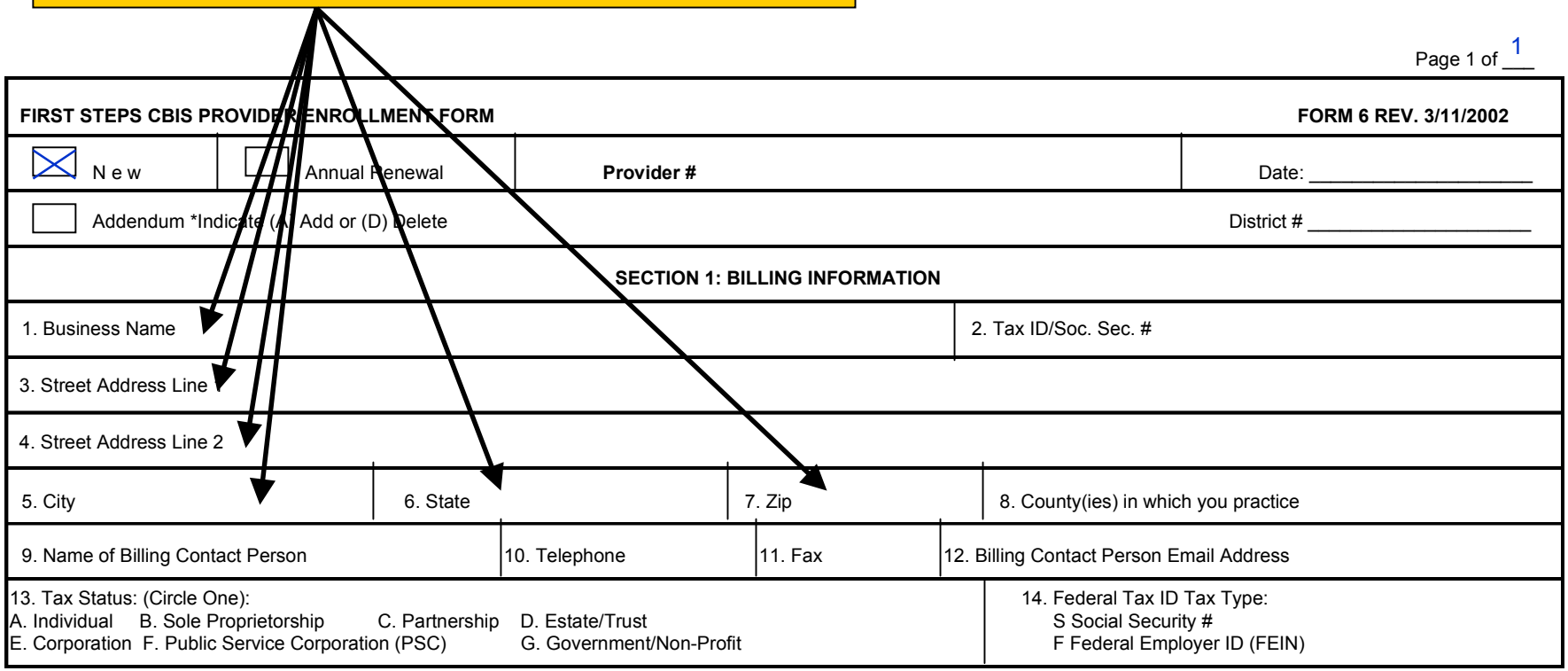
SECTION 1: BILLING INFORMATION

1. Business Name			2. Tax ID/Soc. Sec. #
3. Street Address Line 1			
4. Street Address Line 2			
5. City	6. State	7. Zip	8. County(ies) in which you practice
9. Name of Billing Contact Person	10. Telephone	11. Fax	12. Billing Contact Person Email Address

13. Tax Status: (Circle One): A. Individual B. Sole Proprietorship C. Partnership D. Estate/Trust E. Corporation F. Public Service Corporation (PSC) G. Government/Non-Profit	14. Federal Tax ID Tax Type: S Social Security # F Federal Employer ID (FEIN)

Form 6: CBIS Provider Enrollment

List your legal business name & address



Page 1 of 1

FIRST STEPS CBIS PROVIDER ENROLLMENT FORM — **FORM 6 REV. 3/11/2002**

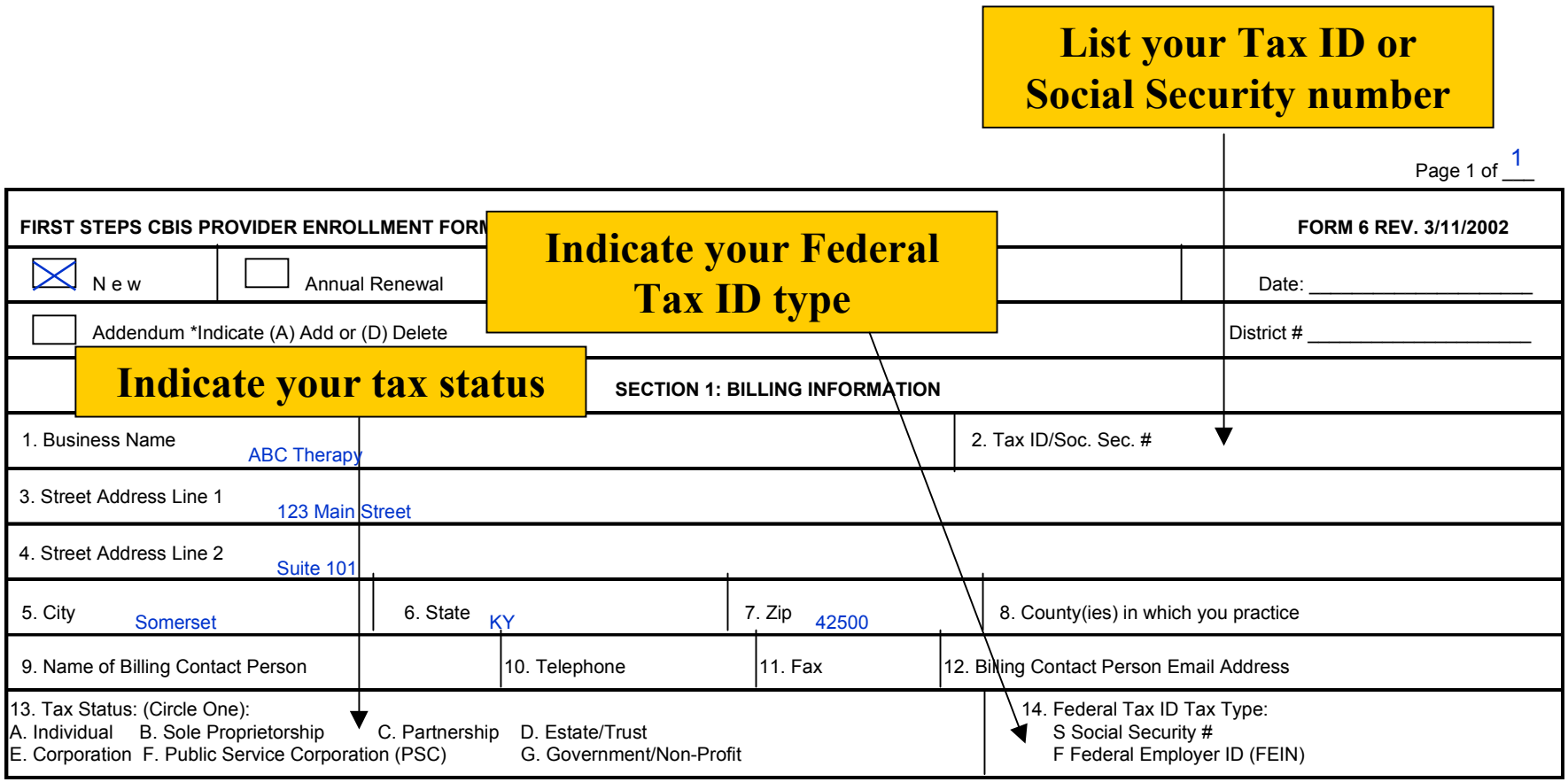
☒ New	☐ Annual Renewal	**Provider #**	Date: _____
☐ Addendum *Indicate (A) Add or (D) Delete			District # _____

SECTION 1: BILLING INFORMATION

1. Business Name			2. Tax ID/Soc. Sec. #
3. Street Address Line 1			
4. Street Address Line 2			
5. City	6. State	7. Zip	8. County(ies) in which you practice
9. Name of Billing Contact Person	10. Telephone	11. Fax	12. Billing Contact Person Email Address

13. Tax Status: (Circle One): A. Individual B. Sole Proprietorship C. Partnership D. Estate/Trust E. Corporation F. Public Service Corporation (PSC) G. Government/Non-Profit	14. Federal Tax ID Tax Type: S Social Security # F Federal Employer ID (FEIN)

Form 6: CBIS Provider Enrollment



Form 6: CBIS Provider Enrollment

Indicate your district & the county(ies) where you practice

Page 1 of 1

FIRST STEPS CBIS PROVIDER ENROLLMENT FORM — **FORM 6 REV. 3/11/2002**

☒ N e w	☐ Annual Renewal	**Provider #**	Date: _____
☐ Addendum *Indicate (A) Add or (D) Delete			District _____

SECTION 1: BILLING INFORMATION

1. Business Name: ABC Therapy			2. Tax ID/Soc. Sec. #: 61-999999
3. Street Address Line 1: 123 Main Street			
4. Street Address Line 2: Suite 101			
5. City: Somerset	6. State: KY	7. Zip: 42500	8. County(ies) in which you practice
9. Name of Billing Contact Person	10. Telephone	11. Fax	12. Billing Contact Person Email Address

13. Tax Status: (Circle One): A. Individual B. Sole Proprietorship (C.) Partnership D. Estate/Trust E. Corporation F. Public Service Corporation (PSC) G. Government/Non-Profit	14. Federal Tax ID Tax Type: S Social Security # (F) Federal Employer ID (FEIN)

Form 6: CBIS Provider Enrollment

List the name, phone #, fax # and email address of the designated contact person. This person will be responsible for informing Provider Relations about changes in the provider's information

Page 1 of 1

FIRST STEPS CBIS PROVIDER ENROLLMENT FORM — **FORM 6 REV. 3/11/2002**

☒ N e w	☐ Annual Renewal	**Provider #**	Date: _____
☐ Addendum *Indicate (A) Add or (D) Delete			District ###

SECTION 1: BILLING INFORMATION

1. Business Name: ABC Therapy			2. Tax ID/Soc. Sec. #: 61-999999
3. Street Address Line 1: 123 Main Street			
4. Street Address Line 2: Suite 101			
5. City: Somerset	6. State: KY	7. Zip: 42500	8. County(ies) in which you practice: Pulaski
9. Name of Billing Contact Person	10. Telephone	11. Fax	12. Billing Contact Person Email Address

13. Tax Status: (Circle One):
A. Individual B. Sole Proprietorship (C.) Partnership D. Estate/Trust
E. Corporation F. Public Service Corporation (PSC) G. Government/Non-Profit

14. Federal Tax ID Tax Type:
S Social Security #
(F) Federal Employer ID (FEIN)

Form 6: CBIS Provider Enrollment

If you have other additional funding sources to provide KEIS services, please list the source and amount. This will not affect reimbursement for services provided through First Steps.

SECTION 2: SOURCES OF ALTERNATE FUNDING	
SOURCE	AMOUNT

Please indicate any additional sources you currently have to provide services to KEIS eligible children. NOTE: This information will not be used in any way to deny payment of KEIS eligible services. This information is simply to provide KEIS with an understanding of how much funding is adequate to meet the early intervention needs of children in Kentucky.

Form 6: CBIS Provider Enrollment

Leave blank

Enter the name of each person who will provide First Steps services under this agreement Do not use nicknames.

If you are a licensed professional enter the name on your license.

E(S)

Enter "SE" Beside Name to Identify Active or Retired State Employee					CENTRAL OFFICE USE ONLY		
*A/D	NAME	SOCIAL SECURITY #	DISCIPLINE CODE(S)	LICENSE #	TRAINING		APPROVED

* LIST ADDITIONAL STAFF ON 6-ADD

Form 6: CBIS Provider Enrollment

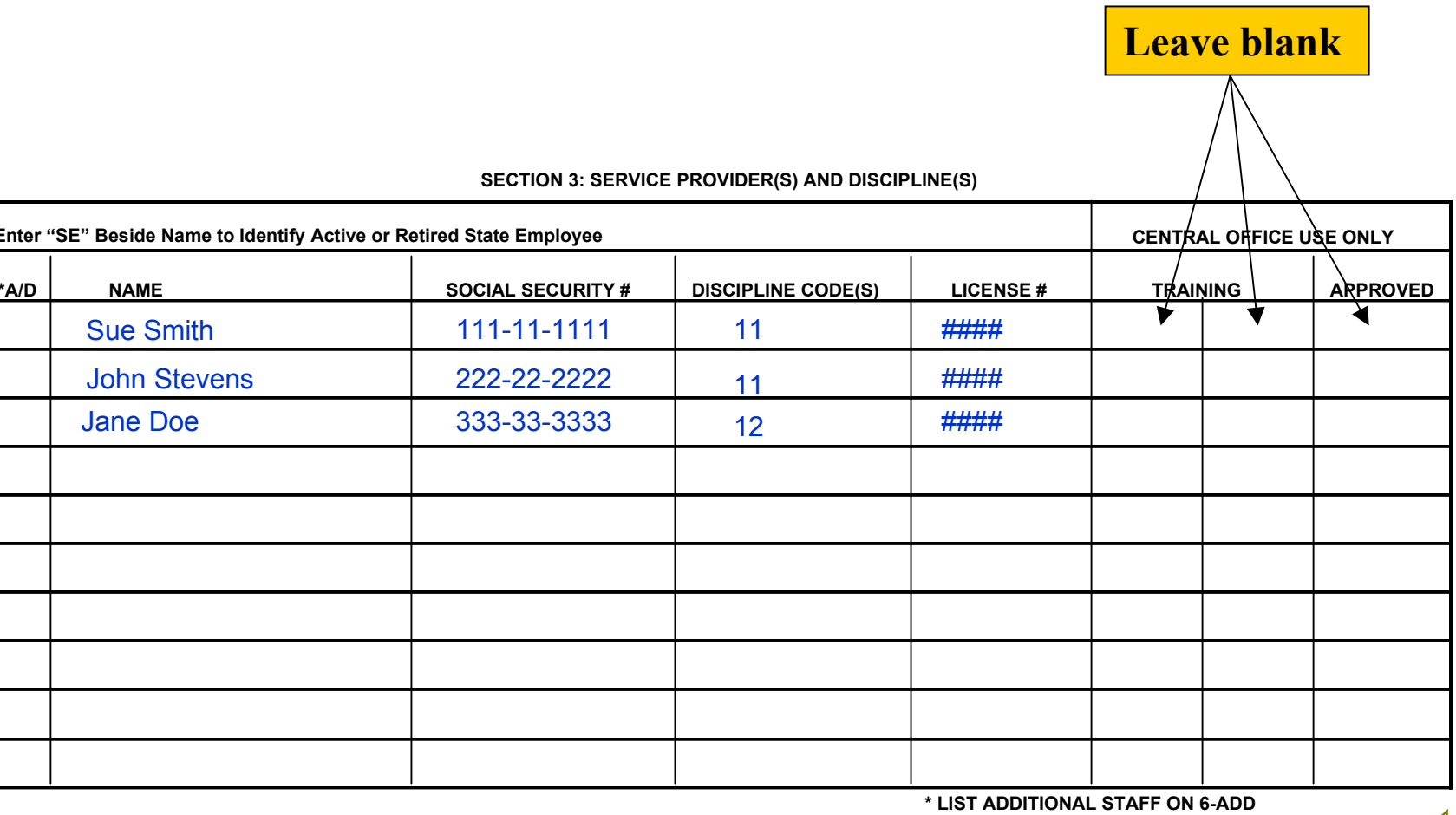
Enter the Social Security #, Discipline code (s) and License # for each person who will provide First Steps services under this agreement

SECTION 3: SERVICE PROVIDER(S) AND DISCIPLINE(S)

Enter "SE" Beside Name to Identify Active or Retired State Employee					CENTRAL OFFICE USE ONLY		
*A/D	NAME	SOCIAL SECURITY #	DISCIPLINE CODE(S)	LICENSE #	TRAINING		APPROVED
	Sue Smith						
	John Stevens						
	Jane Doe						

* LIST ADDITIONAL STAFF ON 6-ADD

Form 6: CBIS Provider Enrollment



Form 6: CBIS Provider Enrollment

PAGE _____ OF _____

Date: _____

FORM 6-ADD Rev. 03/11/2002

FIRST STEPS CBIS PROVIDER ENROLLENT FORM

Provider Name: _____ **Provider CBIS ID:** _____

SECTION 4: ADDITIONAL STAFF

Enter "SE" Beside Name to Identify Active or Retired State Employee					CENTRAL OFFICE USE ONLY		
*A/D	NAME	SOCIAL SECURITY #	DISCIPLINE CODE(S)	LICENSE #	TRAINING		APPROVED

Continue listing staff on this page, if needed

Form 6: CBIS Provider Enrollment

Provider Authorized signature:
I certify, under penalty of law, that the information given in this Enrollment form is correct and completed to the best of my knowledge. I am aware that, should investigation at any time show any falsification, a consideration for suspension from the First Steps Program and/or prosecution for fraud may occur. I hereby authorize the Cabinet to make all necessary verifications concerning the information provided, and authorize licensing boards or other organizations to provide all information that may be sought in connection with the application to participate in the First Steps Program.

Signature: _____
Name: _____
Title: _____

The person who signs Form 6 should be the same person who signed Form 5 as the authorized official.

Print name & title.

Form 8: Electronic Media Addendum

This form outlines the responsibilities of a contracting agency who may submit claims via electronic media, e.g., fax or email.

Even though you may not plan to routinely submit claims electronically, having this form on file will allow you to do so without experiencing delays in processing.

Form 8: Electronic Media Addendum

This required form enables electronic bill submission to CBIS.

Form 8-FY2002
Rev. 8/01

Leave blank

CABINET FOR HEALTH SERVICES

First Steps Provider Agreement Electronic Media Addendum

This addendum to the Provider Agreement is made and entered into as of the

_____day of _____, 20_____, by and between the

Commonwealth of Kentucky, Cabinet for Health Services, hereinafter referred to as the

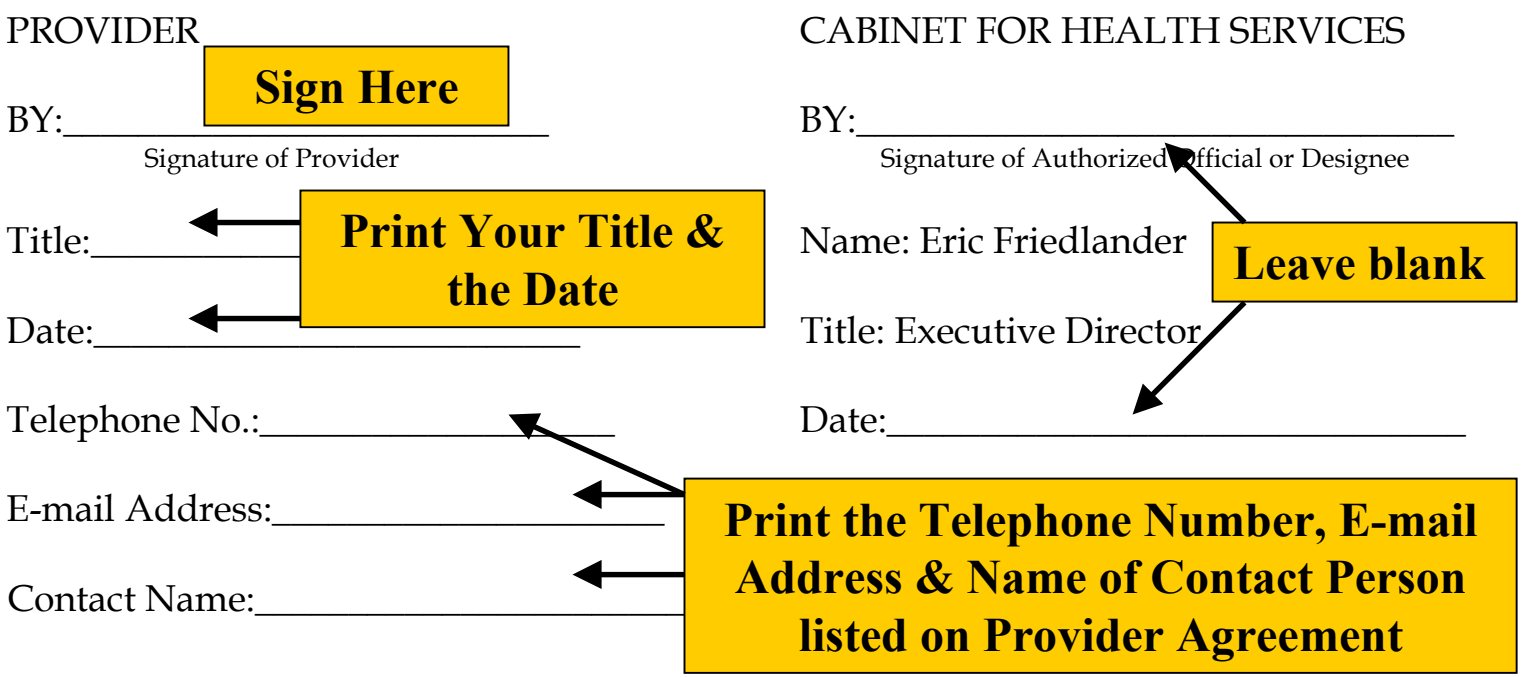
Cabinet, and _____

hereinafter referred to as the Provider.

Enter Name & Address of Provider

Form 8: Electronic Media Addendum

Read the form carefully before signing. **An original signature is required** - do not FAX or email Form 8.



Form 6: CBIS Provider Enrollment

- Mail the signed CBIS Provider Enrollment form with the Provider Agreement to:

  CCSHCN Provider Relations

  982 Eastern Parkway

  Louisville KY 40217

- **Original signatures are required.** FAX and email documents are not accepted.
- Attach any required documents: copy(s) of professional license(s), statement of findings if you check the statement indicating a violation of tax & employment statutes.
- **Any changes to the Provider Enrollment must be submitted on Form 6ADD, the addendum form, and sent to CCSHCN Provider Relations within 10 (ten) days. All communication must include your CBIS-assigned provider number.**
- **Don't forget to submit a new W-9 (an IRS form) whenever you change your name. It ensures that the correct name is linked to your tax I.D. number. This will not affect your CBIS provider**